Montgomery County
Point of Service Plan At-A-Glance

Plan Features	HIGH OPTION		STANDARD OPTION	
	In-Network Benefits Cost to Member	Out-of-Network Benefits* Cost to Member	In-Network Benefits Cost to Member	Out-of-Network Benefits* Cost to Member
Calendar Year Deductible • Individual • Two Party or Family	 None None	 $300 $600	 None None	 $300 $600
Medical Services				
Office Visit	PCP: $10 copay Specialist: $10 copay	20% of Allowed Benefit	PCP: $15 copay Specialist: $30 copay	20% of Allowed Benefit 20% of Allowed Benefit
Surgery	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Well Child Care *(including immunizations)*	$10 copay	To age 18, 20% of Allowed Benefit*	$15 copay	To age 18, 20% of Allowed Benefit*
Routine Physicals	$10 copay	20% of Allowed Benefit limited to one per calendar year	$15 copay	20% of Allowed Benefit limited to one per calendar year
Pap Test	Covered in full	20% of Allowed Benefit*	Covered in full	20% of Allowed Benefit*
Mammograms	Covered in full at approved locations	20% of Allowed Benefit*	Covered in full at approved locations	20% of Allowed Benefit*
Laboratory Tests and X-rays	Covered in full at approved locations	20% of Allowed Benefit	Covered in full at approved locations	20% of Allowed Benefit
Allergy Injections *(serum excluded)*	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Hospital Services				
Inpatient Services	Covered in full	20% of Allowed Benefit	Covered in full after $150 copay per admission	20% of Allowed Benefit
Outpatient Services	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Emergency Services				
Emergency Room	$25 copay (waived if admitted)	Covered in full In-Network level**	$35 copay (waived if admitted)	Covered in full In-Network level**
Ambulance *(when medically necessary)*	Covered in full	Covered at the In-Network level**	Covered in full	Covered at the In-Network level**
Maternity Services				
Pre- and Post-natal Care	$10 copay for first visit (covered in full for remaining visits)	20% of Allowed Benefit	$30 copay for first visit (covered in full for remaining visits)	20% of Allowed Benefit
Hospital Services	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Physical Rehabilitation				
Inpatient and Outpatient Services	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Mental Health & Substance Abuse Services				
Inpatient Services	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Partial Hospitalization *(60 day lifetime maximum)*	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Outpatient Services • Visits 1–5 • Visits 6–30 • Visits 31+	 Covered in full 30% of Allowed Benefit 30% of Allowed Benefit	 20% of Allowed Benefit 35% of Allowed Benefit 50% of Allowed Benefit	 Covered in full 30% of Allowed Benefit 30% of Allowed Benefit	 20% of Allowed Benefit 35% of Allowed Benefit 50% of Allowed Benefit
Additional Medical Services				
Home Health Care *(limited to 90 visits per calendar year)*	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Skilled Nursing Facility *(100 days max)*	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Hospice Care	Covered in full	20% of Allowed Benefit	Covered in full	20% of Allowed Benefit
Routine Vision Services				
Pediatric Visual Screening	Covered in full	20% of Allowed Benefit* (as part of Well Child Care)	Covered in full	20% of Allowed Benefit* (as part of Well Child Care)
Refraction	Not covered	Not covered	Not covered	No covered
Hearing Services				
Childhood Hearing Screening	Covered in full	20% of Allowed Benefit* (as part of Well Child Care)	Covered in full	20% of Allowed Benefit* (as part of Well Child Care)

*All out-of-network services except those marked with an asterisk (*) are subject to the deductible.
** For bonafide medical emergency or accidental injury.

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